

THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 22
THE INSURANCE CONTRACT

500.2204 Settlement of action brought by third party against person insured under commercial liability insurance policy; notice to insured required.

Sec. 2204. Prior to a trial, an insurer shall not settle an action brought by a third party against a person insured under a commercial liability insurance policy issued by the insurer, unless the insurer gives the insured notice of the settlement at least 10 days prior to the settlement. As used in this section, "commercial liability insurance" means insurance which provides indemnification for commercial, industrial, professional, or business liabilities.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986.

Popular name: Act 218

500.2205 Minor's contracts for insurance.

Sec. 2205. A contract for life or disability insurance made by a person between the ages of 16 and 18 years for his benefit, or for the benefit of his father, mother, husband, wife, child, brother or sister, or for the surrender of the insurance, or for the discharge of money payable or benefit accruing thereunder, shall be good and of the same force and effect as though the minor had attained his majority at the time of making the contract. This section shall not have the effect of making a promissory note or other evidence of indebtedness given by a minor in payment of premium or premiums on contracts for insurance valid, either in the hands of the original owner or a subsequent purchaser thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1972, Act 47, Imd. Eff. Feb. 19, 1972.

Popular name: Act 218

500.2206 Minor's capacity to receive insurance benefits; limitations.

Sec. 2206. Any minor domiciled in this state who has attained the age of 18 years shall be deemed competent to receive, and to give a full acquittance and discharge for, a single payment in an amount not exceeding \$2,000.00, or periodical payments in an amount not exceeding \$2,000.00 in any one year, made by a life insurance company or fraternal benefit society as benefits payable upon the death of the insured or maturity of an endowment benefit in compliance with the provisions of a life insurance contract or settlement agreement, if the contract or agreement specifically provides for payments direct to the minor; but no minor shall be deemed competent to alienate the right to the payments or to anticipate the same.

History: Add. 1957, Act 91, Eff. Sept. 27, 1957;—Am. 1964, Act 118, Eff. Aug. 28, 1964.

Popular name: Act 218

500.2207 Insurable interest; personal insurance; rights of beneficiaries, creditors.

Sec. 2207. (1) It shall be lawful for any husband to insure his life for the benefit of his wife, and for any father to insure his life for the benefit of his children, or of any one or more of them; and in case that any money shall become payable under the insurance, the same shall be payable to the person or persons for whose benefit the insurance was procured, his, her or their representatives or assigns, for his, her or their own use and benefit, free from all claims of the representatives of such husband or father, or of any of his creditors; and any married woman, either in her own name or in the name of any third person as her trustee, may cause to be insured the life of her husband, or of any other person, for any definite period, or for the term of life, and the moneys that may become payable on the contract of insurance, shall be payable to her, her representatives or assigns, free from the claims of the representatives of the husband, or of such other person insured, or of any of his creditors; and in any contract of insurance, it shall be lawful to provide that on the decease of the person or persons for whose benefit it is obtained, before the sum insured shall become payable, the benefit thereof shall accrue to any other person or persons designated; and such other person or persons shall, on the happening of such contingency, succeed to all the rights and benefits of the deceased beneficiary or beneficiaries of the policy of insurance, notwithstanding he, she or they may not at the time have any such insurable interest as would have enabled him, her or them to obtain a new insurance; and the proceeds of any policy of life or endowment insurance, which is payable to the wife, husband or children of the insured or to a trustee for the benefit of the wife, husband or children of the insured, including the cash value thereof, shall be exempt from execution or liability to any creditor of the insured; and said exemption shall apply to insurance heretofore or hereafter issued; and shall apply to insurance payable to the above

enumerated persons or classes of persons, whether they shall have become entitled thereto as originally designated beneficiaries, by beneficiary designation subsequent to the issuance of the policy, or by assignment (except in case of transfer with intent to defraud creditors).

(2) If a policy of insurance, or contract of annuity (whether heretofore or hereafter issued) is effected by any person on his own life or on another life in favor of a person other than himself, or (except in cases of transfer with intent to defraud creditors) if a policy of life insurance is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof (other than the insured or the person so effecting such insurance, or his executors or administrators) shall be entitled to the proceeds and avails (including the cash value thereof) against the creditors and representatives of the insured and of the person effecting the same, (whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable in the event that the beneficiary or assignee shall predecease such person, to the person whose life is insured or the person effecting the insurance): Provided, That, subject to the statute of limitations, the amount of any premiums for said insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy: Provided further, That proof that such transfer was made and a particular debt or claim existed at the time of such transfer shall be prima facie evidence of intent to defraud said creditor as to said debt or claim; but the company issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the company shall have written notice at its home office, by or in behalf of a creditor of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specification of the amount claimed.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2209 Insurable interest; married woman; right to proceeds, devise.

Sec. 2209. (1) It shall be lawful for any married woman, by herself, and in her name or in the name of any third person, with his assent, as her trustee, to cause to be insured for her sole use, the life of her husband or the life of any other person, in any life insurance company of any nature whatever, located in either of the states of the United States of America or in Great Britain, for any definite period, or for the term of his natural life; and in case of her surviving her husband, or such other person insured in her behalf, the sum or net amount of the policy of insurance due and payable by the terms of the insurance, shall be payable to her, to and for her own use, free from the claims of the representatives of her husband, or of such other person insured, or of any of his creditors, but such exemption shall not apply where the amount of premium annually paid shall exceed the sum of \$300.00.

(2) In case of the death of the wife before the decease of her husband, or of such other person insured, the amount of the insurance may be made payable after her death to her children, for their use, and to their guardian, if under age, or the amount of the policy may be disposed of by such married woman by a last will and testament.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2210 Definitions; insurable interest; employer; trust; exemption from claims.

Sec. 2210. (1) As used in this section:

(a) "Employee benefit plan" means that term as defined by the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829.

(b) "Employer" means an individual, sole proprietorship, partnership, firm, corporation, association, or any other legal entity, which has 1 or more employees and is legally doing business in this state.

(c) "Trust" means a trust established by an employer.

(2) Notwithstanding any other section of this act, an employer or a trust has an insurable interest in, and may, with the written consent of the insured, insure on an individual or group basis for its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. An employer or a trust may insure the lives of the employer's nonmanagement employees and its retired employees only if those persons give written consent to be insured and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer shall not retaliate in any manner against an employee or a retired employee for refusing consent to be insured.

(3) Notwithstanding any other section of this act, a trust maintained for the purpose of providing for the cost of benefits under an employee benefit plan maintained for employees or retired employees has an insurable interest in, and may, with the acquiescence of the insured, insure on an individual or group basis for

its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. A trust may insure the life of a nonmanagement employee and a retired employee only if that person is given written notice of the coverage, he or she has not notified either the employer or the trust in writing that he or she does not want to be insured for the coverage, and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer or a trust shall not retaliate in any manner against an employee or a retired employee for providing the written notice that he or she does not want to be insured for the coverage.

(4) The proceeds of any policy or certificate issued pursuant to subsection (2) or (3) are exempt from the claims of any creditor or dependent of the insured.

History: Add. 1990, Act 349, Eff. Mar. 28, 1991;—Am. 1994, Act 227, Imd. Eff. June 27, 1994;—Am. 1998, Act 222, Imd. Eff. July 1, 1998.

Popular name: Act 218

500.2211 Consent of insured.

Sec. 2211. (1) Any individual who has an insurable interest in the life of another human being shall not insure that other human being's life for the individual's benefit unless the human being whose life is to be insured consents to be insured in writing. That person's signature on the application for insurance constitutes consent.

(2) This section applies to life insurance policies and certificates of \$10,000.00 or more delivered or issued for delivery in this state on and after 30 days after the effective date of this section. This section does not apply if the human being whose life is to be insured is less than 18 years of age.

History: Add. 1998, Act 91, Imd. Eff. May 14, 1998.

Popular name: Act 218

500.2212 Insurable interest in life of individual.

Sec. 2212. Notwithstanding any other section of this act, an organization described in and qualified under section 501(c)(3) of the internal revenue code of 1986, 26 U.S.C. 501, has an insurable interest in the life of an individual who gives written consent to the ownership or purchase of a policy on his or her life.

History: Add. 1996, Act 572, Imd. Eff. Jan. 16, 1997.

Popular name: Act 218

500.2212a Policy or certificate issued under chapter 34 or 36; description of terms, conditions, and information; written request; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate issued under chapter 34 or 36 shall provide a written form in plain English to insureds upon enrollment that describes the terms and conditions of the insurer's policies and certificates. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

- (a) The service area.
- (b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.
- (c) Emergency health coverages and benefits.
- (d) Out-of-area coverages and benefits.
- (e) An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.
- (f) Provision for continuity of treatment if a provider's participation terminates during the course of an insured person's treatment by that provider.
- (g) The telephone number to call to receive information concerning grievance procedures.
- (h) How the covered benefits apply in the evaluation and treatment of pain.
- (i) A summary listing of the information available pursuant to subsection (2).

(2) An insurer shall provide upon request to insureds covered under a policy or certificate issued under section 3405 or 3631 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the policy or certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of participating health professionals, including, but not limited to,

participating health professionals who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

- (i) Relevant professional degrees.
 - (ii) Date of certification by the applicable nationally recognized boards and other professional bodies.
 - (iii) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.
- (c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.
- (d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.
- (e) Indication of the financial relationships between the insurer and any closed provider panel including all of the following as applicable:
- (i) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.
 - (ii) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.
 - (iii) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.
- (f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).
- (3) Upon request, any of the information provided under subsection (2) shall be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.
- (4) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American board of medical specialties or another appropriate national health professional organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 424, Eff. Apr. 1, 1999;—Am. 2001, Act 235, Imd. Eff. Jan. 3, 2002.

Compiler's note: Enacting section 1 of Act 235 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302."

Popular name: Act 218

500.2212b Termination of participation between primary care physician and insurer; notice to insured; effect of termination; definitions.

Sec. 2212b. (1) This section applies to a policy or certificate issued under section 3405 or 3631 and to a health maintenance organization contract.

(2) If participation between a primary care physician and an insurer terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each insured who has chosen the physician as his or her primary care physician. If an insured is in an ongoing course of treatment with any other physician that is participating with the insurer and the participation between the physician and the insurer terminates, the physician may provide written notice of this termination to the insured within 15 days after the physician becomes aware of the termination. The notices under this subsection may also describe the procedure for continuing care under subsections (3) and (4).

(3) If participation between an insured's current physician and an insurer terminates, the insurer shall permit the insured to continue an ongoing course of treatment with that physician as follows:

- (a) For 90 days from the date of notice to the insured by the physician of the physician's termination with the insurer.
- (b) If the insured is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.
- (c) If the insured is determined to be terminally ill prior to a physician's termination or knowledge of the termination and the physician was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the terminal illness.

(4) Subsection (3) applies only if the physician agrees to all of the following:

- (a) To continue to accept as payment in full reimbursement from the insurer at the rates applicable prior to the termination.

(b) To adhere to the insurer's standards for maintaining quality health care and to provide to the insurer necessary medical information related to the care.

(c) To otherwise adhere to the insurer's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

(5) An insurer shall provide written notice to each participating physician that if participation between the physician and the insurer terminates, the physician may do both of the following:

(a) Notify the insurer's insureds under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (3) and (4).

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

(7) As used in this section:

(a) "Physician" means an allopathic physician, osteopathic physician, or podiatric physician.

(b) "Terminal illness" means that term as defined in section 5653 of the public health code, 1978 PA 368, MCL 333.5653.

(c) "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a participation agreement or contract between a physician and an insurer, but does not include a termination by the insurer for failure to meet applicable quality standards or for fraud.

History: Add. 1999, Act 230, Eff. July 1, 2000;—Am. 2000, Act 486, Imd. Eff. Jan. 11, 2001.

Popular name: Act 218

500.2213 Internal formal grievance procedure; approval by commissioner; contents; person authorized to act on behalf of insured or enrollee; section inapplicable to provider complaint and insurance listed in right to independent review act; definitions.

Sec. 2213. (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, or 36 that includes all of the following:

(a) Provides for a designated person responsible for administering the grievance system.

(b) Provides a designated person or telephone number for receiving complaints.

(c) Ensures full investigation of a complaint.

(d) Provides for timely notification in plain English to the insured or enrollee as to the progress of an investigation.

(e) Provides an insured or enrollee the right to appear before the board of directors or designated committee or the right to a managerial-level conference to present a grievance.

(f) Provides for notification in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation and for advisement of the insured's or enrollee's right to review the grievance by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) Provides summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(h) Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) Provides for copies of all complaints and responses to be available at the principal office of the insurer or health maintenance organization for inspection by the commissioner for 2 years following the year the complaint was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business

days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.

(l) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(ii) Benefits or claims payment, handling, or reimbursement for health care services.

(iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002.

Popular name: Act 218

500.2213a Expenses incurred by commissioner; calculation; assessment.

Sec. 2213a. (1) All actual and necessary expenses incurred by the commissioner under section 2213 shall be calculated by the commissioner by June 30 of each year for the immediately preceding fiscal year. Except as otherwise provided in subsection (2), the commissioner shall divide these expenses among all insurers who issue a policy or certificate under chapter 34 or 36 in this state on a pro rata basis according to the direct written premiums reported in each insurer's annual statement for the immediately preceding calendar year by each of those insurers. This assessment shall be paid within 30 days after receipt of the assessment and is in addition to the regulatory fee provided for in section 224.

(2) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002.

Popular name: Act 218

500.2213b Renewal or continuation of individual or group policy; guaranteed renewal; short-term or 1-time limited duration policy or certificate.

Sec. 2213b. (1) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical individual policy under chapter 34 shall renew or continue in force the policy at the option of the individual.

(2) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical group policy or certificate under chapter 36 shall renew or

continue in force the policy or certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) Subsections (1), (2), and (3) do not apply to a short-term or 1-time limited duration policy or certificate of no longer than 6 months.

(5) For the purposes of this section and section 3406f, a short-term or 1-time limited duration policy or certificate of no longer than 6 months is an individual health policy that meets all of the following:

(a) Is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy.

(b) Is nonrenewable, provided that the health insurer may provide coverage for 1 or more subsequent periods that satisfy subdivision (a), if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy.

(c) Does not cover any preexisting conditions.

(d) Is available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the health insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(6) An insurer that delivers, issues for delivery, or renews in this state a short-term or 1-time limited duration policy or certificate of no longer than 6 months shall provide the following to the commissioner:

(a) By no later than February 1, 1999, a written report that discloses both of the following:

(i) The gross written premium for short-term or 1-time limited duration policies or certificates of no longer than 6 months issued in this state during the 1996 calendar year.

(ii) The gross written premium for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state during the 1996 calendar year other than policies or certificates described in subparagraph (i).

(b) By no later than March 31, 1999 and annually thereafter, a written annual report that discloses both of the following:

(i) The gross written premium for short-term or 1-time limited duration policies or certificates issued in this state during the preceding calendar year.

(ii) The gross written premium for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state during the preceding calendar year other than policies or certificates described in subparagraph (i).

(7) The commissioner shall maintain copies of reports prepared pursuant to subsection (6) on file with the annual statement of each reporting insurer. The commissioner shall annually compile the reports received under subsection (6). The commissioner shall provide this annual compilation to the senate and house of representatives standing committees on insurance issues no later than the June 1 immediately following the February 1 or March 31 date for which the reports under subsection (6) are provided.

(8) In each calendar year, a health insurer shall not continue to issue short-term or 1-time limited duration policies or certificates if to do so the collective gross written premiums on those policies or certificates would total more than 10% of the collective gross written premiums for all individual expense-incurred hospital, medical, or surgical policies or certificates issued or delivered in this state either directly by that insurer or through a corporation that owns or is owned by that insurer.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999.

Popular name: Act 218

500.2213c Disability income insurer; internal grievance procedure; establishment; contents; “grievance” defined.

Sec. 2213c. (1) Each disability income insurer shall establish an internal grievance procedure for persons covered under a disability income policy, certificate, or contract.

(2) An internal grievance procedure under subsection (1) shall include all of the following:

(a) Provide for a designated person responsible for administering the grievance procedure.

(b) Provide for a designated person or telephone number for receiving grievances.

(c) Ensure full investigation of a grievance.

(d) Provide for timely notification to the insured as to the progress of an investigation.

(e) Provide for the insured to have the right to have the grievance reviewed by a managerial-level person or group.

(f) Provide for notification to the insured of the results of the insurer's investigation and, if the insurer upholds its prior determination on the grievance, for advising the insured of his or her right to present the grievance to the commissioner for review.

(g) Provide that a final determination will be made in writing by the insurer not later than 45 calendar days after a grievance is submitted in writing by the insured unless the insurer requires an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed 45 days from the end of the initial period unless the initial period is extended due to the insured's failure to submit information necessary to decide the claim on appeal. If the extension is due to an insured's failure to submit information, the period for making the determination shall be tolled until the date the insured responds to the request for additional information.

(h) Provide for copies of all grievances and responses to be available at the principal office of the insurer for inspection by the commissioner for 2 years following the year the grievance was filed.

(3) As used in this section, "grievance" means a written complaint by an insured concerning the payment of benefits under a disability income insurance policy.

History: Add. 2002, Act 707, Imd. Eff. Dec. 30, 2002.

Popular name: Act 218

500.2213d Uniform prescription drug information card or other technology.

Sec. 2213d. (1) A health benefit plan that provides coverage or administers a plan that provides coverage for prescription drugs or devices and that issues, uses, or requires a card or other technology for prescription claims submission and adjudication shall issue for the plan's insureds, enrollees, members, or participants a uniform prescription drug information card or other technology as provided for in this section.

(2) By July 1, 2003, the commissioner shall develop a uniform prescription drug information card and uniform prescription drug information technology based on the standards and format approved by the national council for prescription drug programs pharmacy ID card implementation guide. The card and technology shall include all of the national council for prescription drug programs standard information required by the health plan for submission and adjudication of claims for prescription drug or device benefits, or at a minimum contain all of the following labeled information:

(a) The card issuer name or logo on the front of the card.

(b) The cardholder's name and identification number, which shall be displayed on the front of the card.

(c) Complete information for electronic transaction claims routing including all of the following:

(i) The international identification number labeled as RxBIN.

(ii) The processor control number labeled as RxPCN, if required for proper routing of electronic claim transactions for prescription benefits.

(iii) The group number labeled as RxGrp, if required for proper routing of electronic claim transactions for prescription benefits.

(d) The name and address of the benefits administrator or other entity responsible for prescription claims submission, adjudication, or pharmacy provider correspondence for prescription benefits claims.

(e) A help desk telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

(3) All information required by subsection (2) that is necessary for submission and adjudication of claims for prescription drug or device benefits, exclusive of information that can be derived from the prescription, shall be included in a clear, readable, and understandable manner on the uniform prescription drug information card or other technology issued by the health plan. The content and format of all information required by subsection (2) shall be in the current content and format required by the health plan for electronic claims routing, submission, and adjudication.

(4) The uniform prescription drug information card or uniform prescription drug information technology developed under this section shall be issued by a health plan upon enrollment and reissued upon any change in coverage that impacts data contained on the card or technology. However, a health plan is not required to issue a new uniform prescription drug information card or other technology more often than once in a calendar year and if a health plan issues stickers or another similar mechanism to the insureds, enrollees, members, or participants to update the cards, then the health plan is not required to issue new uniform prescription drug information cards or other technology more often than once in 3 years from the issuance of the first stickers or other similar mechanisms. This subsection does not prevent a health plan from reissuing updated new uniform prescription drug information cards or other technology on a more frequent basis.

(5) The uniform prescription drug information card or other technology may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using, or requiring the uniform prescription drug information card or other technology to issue, use, or require a separate card for prescription

coverage, provided that the card or other technology can accommodate the information necessary to process the claim as required by subsection (2).

(6) As used in this section, "health plan" means all of the following but does not include a department of community health pharmacy program:

(a) An insurer providing benefits under an expense-incurred hospital, medical, or surgical policy or certificate, but does not include any of the following:

(i) Any policy or certificate that provides coverage only for any of the following:

(A) Vision.

(B) Dental.

(C) Specific diseases.

(D) Accidents.

(E) Credit.

(ii) Hospital indemnity policy or certificate.

(iii) Disability income policy or certificate.

(iv) Coverage issued as a supplement to liability insurance.

(v) Medical payments under automobile, homeowners, or worker's compensation insurance.

(b) A MEWA regulated under chapter 70 that provides hospital, medical, or surgical benefits.

(c) A health maintenance organization licensed or issued a certificate of authority in this state.

(d) A third party administrator licensed under the third party administrator act, 1984 PA 218, MCL 550.901 to 550.962.

History: Add. 2002, Act 708, Eff. Jan. 1, 2003.

Compiler's note: Enacting section 1 of Act 708 of 2002 provides:

"Enacting section 1. (1) This amendatory act takes effect January 1, 2003.

(2) This amendatory act applies to all health plan coverages issued or renewed on or after July 1, 2005."

Enacting section 2 of Act 708 of 2002 provides:

"Enacting section 2. It is the intent of the legislature that pharmacists, by July 1, 2008, be able to obtain information on and submit claims for prescription drug or device benefits by electronic means, including, but not limited to, the internet."

Popular name: Act 218

500.2214 Disability insurance; application, use as evidence.

Sec. 2214. The insured shall not be bound by any statement made in an application for a disability insurance policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make a written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 15 days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2216 Life or disability insurance; alteration of application.

Sec. 2216. No alteration of any written application for any life or disability insurance policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.2218 Disability insurance; false statement in application; effect.

Sec. 2218. The falsity of any statement in the application for any disability insurance policy covered by chapter 34 of this code may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(1) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless the misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make the contract.

(2) A representation is a statement as to past or present fact, made to the insurer by or by the authority of the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an

inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(3) In determining the question of materiality, evidence of the practice of the insurer which made the contract with respect to the acceptance or rejection of similar risks shall be admissible.

(4) A misrepresentation that an applicant for life, accident or health insurance has not had previous medical treatment, consultation or observation, or has not had previous treatment or care in a hospital or other like institution, shall be deemed, for the purpose of determining its materiality, a misrepresentation that the applicant has not had the disease, ailment or other medical impairment for which such treatment or care was given or which was discovered by any licensed medical practitioner as a result of such consultation or observation. If in any action to rescind any contract or to recover thereon, any misrepresentation is proved by the insurer, and the insured or any other person having or claiming a right under the contract, shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1957, Act 91, Eff. Sept. 27, 1957.

Popular name: Act 218

500.2220 Life insurance; solicitor as agent of insurer.

Sec. 2220. Any person who shall solicit an application for insurance upon the life of another shall, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, be regarded as the agent of the insurer and not the agent of the insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2226 Life insurance; benefits, manner of payment, period, and premiums to be contained in policy.

Sec. 2226. (1) A life insurer shall not make with or issue to any citizen or resident of this state any contract of life insurance that does not distinctly state the amount of the life benefits, the manner of payment, the period of the continuance, and the amount of the annual, semi-annual, or quarterly premium, or by which the payment of the life benefit assured shall be contingent upon the payment of assessments made upon surviving members and shall be made in accordance with the statutes now or hereafter regulating the business of life insurance. For a universal or variable life insurance contract, the insurer shall clearly and specifically state the amount of benefits or manner in which the benefits are calculated.

(2) Every policy of life insurance hereafter issued or delivered within this state by any life insurer doing business within this state shall contain the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, bylaws, rules, application, or other writing unless the same are endorsed upon or attached to the policy when issued.

(3) For standard provisions required in life insurance contracts see chapters 40, 42, and 44.

History: 1956, Act 218, Eff. Jan. 1, 1955;—Am. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.2227 Withholding final settlement amount; notice; escrow procedure to be followed by city, village, or township; disposition of money by local treasurer; commingling funds prohibited; retention of interest to defray expenses; forwarding policy proceeds; proof; effect of failure to provide reasonable proof; liability; applicability of section; definitions.

Sec. 2227. (1) If a claim is filed for a loss to insured real property due to fire, explosion, vandalism, malicious mischief, wind, hail, riot, or civil commotion and a final settlement is reached on the loss to the insured real property, an insurer shall withhold from payment 25% of the actual cash value of the insured real property at the time of the loss or 25% of the final settlement, whichever is less. For residential property, the 25% settlement or judgment withheld shall not exceed \$6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index. The commissioner shall notify annually all insurance companies transacting property insurance in this state as to the new adjusted amount. At the time that 25% of the settlement or judgment is withheld, the insurer shall give notice of the withholding to the treasurer of the city, village, or township in which the insured real property is located, to the insured, and to any mortgagee having an existing lien or liens against the insured real property, if the mortgagee is named on the policy. In the case of a judgment, notice shall also be provided to the court in which judgment was entered. The notice shall include all of the following:

(a) The identity and address of the insurer.

- (b) The name and address or forwarding address of each policyholder, including any mortgagee.
 - (c) Location of the insured real property.
 - (d) The date of loss, policy number, and claim number.
 - (e) The amount of money withheld.
 - (f) A statement that the city, village, or township may have the withheld amount paid into a trust or escrow account established for the purposes of this section if within 15 days after the mailing of the notice the city, village, or township states that the money should be withheld to protect the public health and safety; otherwise, the withheld amount shall be paid to the insured 15 days after the mailing of the notice.
 - (g) An explanation of the provisions of this section.
- (2) In order for a city, village, or township to escrow the amount withheld by the insurer, and to retain that amount, the following procedure shall be used:
- (a) An authorized representative of the city, village, or township shall request the insurer to pay the withheld amount into an escrow account maintained by the treasurer of the city, village, or township. A final settlement that exceeds 49% of the insurance on the insured real property is prima facie evidence that the damaged insured structure violates existing health and safety standards of the city, village, or township and constitutes cause for the escrowing of the withheld amount as surety for the repair, replacement, or removal of the damaged structure.
 - (b) In the case of a settlement, the request under subdivision (a) shall be sent to the insurer with a copy to the insured and any mortgagees. The copy to the insured shall contain the notice required under subdivision (d). Upon receipt of the request, the insurer shall forward the withheld amount to the treasurer of the city, village, or township, and shall provide notice of the forwarding to the insured and any mortgagees.
 - (c) In the case of a judgment, the request under subdivision (a) shall be sent to the insurer with a copy to the insured, any mortgagees, and the court in which judgment was entered. The copy to the insured shall contain the notice required under subdivision (d). Upon the motion of the city, village, or township, the court shall order the withheld amount transmitted to the treasurer of the city, village, or township.
 - (d) The city, village, or township shall notify the insured that the insured has 10 days from the date of the mailing of the notice to object to the city's, village's, or township's retention of the withheld amount. The notice shall identify the authorized representative of the city, village, or township that the insured should address his or her objections to and shall state that the insured may do either of the following:
 - (i) Seek resolution with the representative of the city, village, or township designated to receive and resolve objections under this section. The city, village, or township shall make a final determination and shall notify the insured of that determination not later than 30 days after receipt of notice that the insured wishes to seek resolution under this subparagraph. This final determination shall include notice to the insured that if the insured is still dissatisfied with the city's, village's, or township's determination, the insured may seek relief in circuit court.
 - (ii) Seek relief in the circuit court.
- (3) Upon receipt of money and information from an insurer as prescribed in subsections (1) and (2), the local treasurer shall record the information and the date of receipt of the money and shall immediately deposit the money in a trust or escrow account established for the purposes of this section. The account may be interest-bearing. If the mortgage on the insured property is in default, the treasurer of the city, village, or township, upon written request from a first mortgagee of property with respect to which policy proceeds were withheld and placed into a trust or escrow account under subsections (1) and (2) and this subsection, shall release to the mortgagee all or any part of the policy proceeds received by the city, village, or township with respect to that property, not later than 10 days after receipt of the written request by the mortgagee, to the extent necessary to satisfy any outstanding lien of the mortgagee.
- (4) Except as provided in subsection (7), money deposited in an account pursuant to subsection (3) shall not be commingled with city, village, or township funds. Any interest earned on money placed in a trust or escrow account shall be retained by the city, village, or township to defray expenses incurred under this section.
- (5) Except as provided in subdivision (c), the policy proceeds deposited under subsection (3) shall immediately be forwarded to the insured when the authorized representative of the city, village, or township designated by the governing body of the city, village, or township receives or is shown reasonable proof of any of the following:
- (a) That the damaged or destroyed portions of the insured structure have been repaired or replaced, except to the extent that the amount withheld under this subsection is needed to complete repair or replacement.
 - (b) That the damaged or destroyed structure and all remnants of the structure have been removed from the land on which the structure or the remnants of the structure were situated, in compliance with the local code requirements of the city, village, or township in which the structure was located.

(c) That the insured has entered into a contract to perform repair, replacement, or removal services for the insured real property and that the insured consents to payment of funds directly to the licensed contractor performing the services upon completion. Funds released under this subdivision may be forwarded only to a licensed contractor performing services on the insured property.

(6) Reasonable proof required under subsection (5) includes any of the following:

(a) Originals or copies of pertinent verifiable contracts, invoices, receipts, and other similar papers evidencing both the work performed or to be performed and the materials used or to be used by all contractors performing repair, replacement, or removal services with respect to the insured real property, other than a licensed contractor subject to subdivision (b).

(b) An affidavit executed by the licensed contractor that has performed the greatest amount of repair or replacement work on the structure, or that has done most of the clearing and removal work if structure repair or replacement is not to be performed. The licensed contractor shall attach to the affidavit all pertinent contracts, invoices, and receipts and shall swear that these attached papers correctly indicate the nature and extent of the work performed to date by the licensed contractor and the materials used.

(c) An inspection of the insured real property to verify that repair, replacement, or clearing has been completed in accordance with subsection (5).

(7) If with respect to a loss, reasonable proof is not received by or shown to an authorized representative of the city, village, or township designated by the governing body of the city, village, or township within 120 days after the policy proceeds portion was received by the treasurer, the city, village, or township shall use the retained proceeds to secure, repair, or demolish the damaged or destroyed structure and clear the property in question, so that the structure and property are in compliance with local code requirements and applicable ordinances of the city, village, or township. Any unused portion of the retained proceeds shall be returned to the insured. The city, village, or township may extend the 120-day time period listed in this subsection.

(8) There is no liability on the part of, and a cause of action does not arise against, an insurer or an agent or employee of an insurer for withholding or transferring money in the course of complying or attempting to comply with this section. If there is a dispute with a lienholder concerning the distribution of an amount withheld from payment under this section, the insurer may file an action in circuit court to identify all parties that may have a financial interest in the withheld amount and to determine how the withheld amount should be distributed.

(9) This section applies only to property located in a city, village, or township described in subsection (12) if the city, village, or township pursuant to a resolution by its governing body notifies the commissioner in writing that the city, village, or township has established a trust or escrow account to be used as prescribed in this section and intends to uniformly apply this section with respect to all property located within the city, village, or township following written notification to the commissioner. The commissioner shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting property insurance in this state.

(10) A city, village, or township may apply to be added to the list by making a written request for addition to the commissioner. When a written request for addition from a city, village, or township has been received by the commissioner, an amended list shall be prepared and distributed indicating the addition. The addition shall be effective on the date specified by the commissioner in the amendment. The commissioner shall notify the city, village, township, and insurance companies of the effective date of the addition which shall be effective not less than 30 days after receipt of notice by the insurance company. A city, village, or township shall not apply this section to any loss that occurred before the effective date of the addition.

(11) A city, village, or township may request to be deleted from the list or may cease to apply this section for a period of not less than 6 months upon not less than 30 days' written notice to the commissioner. After receipt of a request to be deleted from the list, the commissioner shall prepare and distribute an amendment to the list indicating the deletion. The deletion shall be effective on the date specified by the commissioner in the amendment. The commissioner shall notify the city, village, township, and insurance companies of the effective date of the deletion which shall be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(12) This section applies only to insured real property located in cities, villages, and townships that are located in counties with a population of 425,000 or more and to insured real property located in cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more. This section applies to insured real property located in a city, village, or township that has elected to apply this section as provided in subsection (9) or (10) or that has been included in this section as provided in subsection (13).

(13) Cities, villages, and townships located in counties with a population of 425,000 or more and cities,

villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more and that are on the list prepared by the commissioner under section 2845(9) or (10) on October 1, 1998 are automatically included as participants in the procedure established in this section unless the city, village, or township makes a written request to be deleted pursuant to subsection (11).

(14) The commissioner shall prepare and distribute to all insurance companies transacting property insurance in this state by November 1, 1998 new lists indicating which cities, villages, and townships are subject to this section and which cities, villages, and townships are subject to section 2845.

(15) The withholding requirements of this section do not apply if all of the following occur:

(a) Within 15 days after agreement on a final settlement between the insured and the insurer, the insured has filed with the insurer evidence of a contract to repair as described in subsection (6).

(b) The insured consents to the payment of funds directly to the licensed contractor performing the repair services. Funds released under this subdivision may be forwarded only to a licensed contractor performing the repair services on the insured property.

(c) On receipt of the contract to repair, the insurer gives notice to the city, village, or township in which the property is situated that there will not be a withholding under this section because of the repair contract.

(16) If the insured and the insurer have agreed on the demolition costs or the debris removal costs as part of the final settlement of the real property insured claim, the insurer shall withhold 1 of the following sums, whichever sum is the largest, and shall pay that sum in accordance with this section:

(a) The agreed cost of demolition or debris removal.

(b) Twenty-five percent of the actual cash value of the insured real property at the time of loss so long as this amount for residential property does not exceed \$6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index.

(c) Twenty-five percent of the final settlement of the insured real property claim so long as this amount for residential property does not exceed \$6,000.00 adjusted annually beginning June 1, 1999 in accordance with the consumer price index.

(17) This section applies only to final settlements that exceed 49% of the insurance on the insured real property.

(18) If an insurer withholds payment under a policy in good faith because of suspected arson, fraud, or other question concerning coverage, this section does not apply until the issue or question is resolved and final settlement is made.

(19) As used in this section:

(a) "Consumer price index" means that term as defined in section 2080.

(b) "Final settlement" means a determination of the amount due and owing to the insured for a loss to insured real property, but does not include contents damage, losses to personal property, or additional coverage not contained in the building coverage portion of the fire insurance policy, which determination is made by any of the following means:

(i) Acceptance of a proof of loss by the insurer.

(ii) Execution of a release by the insured.

(iii) Acceptance of an arbitration award by both the insured and the insurer.

(iv) Judgment of a court of competent jurisdiction.

(c) "Home insurance" means that term as defined in section 2103.

(d) "Residential property" means property on which home insurance can be issued.

History: Add. 1998, Act 217, Eff. (see compiler's note).

Compiler's note: Enacting section 1 of Act 217 of 1998 provides:

"Enacting section 1. (1) Section 2227(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (15), (16), (17), (18), and (19) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, take effect on January 1, 1999 and apply to any loss that occurs on and after January 1, 1999.

"(2) Section 2227(14) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, takes effect October 1, 1998."

Popular name: Act 218

500.2228 Automobile insurance; contents of policy.

Sec. 2228. (1) No policy of insurance against fire, theft, property damage, collision, and/or liability in connection with automobile coverage shall be issued, unless the premium and amount of coverage is stated in the policy.

(2) For other provisions required in such policies, see chapter 30 of this code (casualty insurance contracts).

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2230 Mutual insurers other than life; contents of policy.

Sec. 2230. Mutual insurers, other than life insurers, may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance, which are not inconsistent or in conflict with any law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law, and a copy of such policy and endorsement, if any, shall have been first filed with and shall not have been disapproved by the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2232 Reciprocal insurers; contents of policy.

Sec. 2232. A reciprocal insurer may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with the law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, shall be held to conform thereto in substance if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2235 Written notice to insured under worker's compensation insurance policy.

Sec. 2235. At least annually, in conjunction with a renewal notice, a bill, or other notice of payment due issued in connection with a policy of worker's compensation insurance, an insurer shall send to each insured a written notice containing all of the following statements:

(a) A description of the insured's right to all pertinent rating information within a reasonable time after making a written request and paying reasonable charges.

(b) A description of the procedures whereby an insured or an insured's representatives may request a review of the way in which the insured's rates and premiums have been determined, including a statement of the insured's right to appeal the result of the review to the commissioner.

(c) Relevant information regarding the right of an insured to obtain a payroll audit under section 2008.

(d) Relevant information regarding the right of an insured to request a conference with a management representative to review reserve or redemption decisions by the insurer under section 2419.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983.

Popular name: Act 218

500.2236 Forms generally; filing; approval; type size; effect of membership in or subscription to rating organization; substitute form; readability score and other requirements; approval of changes or additions; notice of disapproval or withdrawal of approval; hearing; separate violation; penalty; applicability of filing requirements; "exempt commercial policyholder" defined; court review of order.

Sec. 2236. (1) A basic insurance policy form or annuity contract form shall not be issued or delivered to any person in this state, and an insurance or annuity application form if a written application is required and is to be made a part of the policy or contract, a printed rider or indorsement form or form of renewal certificate, and a group certificate in connection with the policy or contract, shall not be issued or delivered to a person in this state, until a copy of the form is filed with the insurance bureau and approved by the commissioner as conforming with the requirements of this act and not inconsistent with the law. Failure of the commissioner to act within 30 days after submittal constitutes approval. All such forms, except policies of disability insurance as defined in section 3400, shall be plainly printed with type size not less than 8-point unless the commissioner determines that portions of such a form printed with type less than 8-point is not deceptive or misleading.

(2) An insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization, licensed under section 2436 or 2630, which makes such filings and by filing with the commissioner a copy of its authorization of the rating organization to make the filings on its behalf. Every member of or subscriber to a rating organization shall adhere to the form filings made on its behalf by the organization except that an insurer may file with the commissioner a substitute form, and thereafter if a

subsequent form filing by the rating organization affects the use of the substitute form, the insurer shall review its use and notify the commissioner whether to withdraw its substitute form.

(3) Beginning January 1, 1992, the commissioner shall not approve a form filed pursuant to this section providing for or relating to an insurance policy or an annuity contract for personal, family, or household purposes if the form fails to obtain the readability score or meet the other requirements of this subsection, as applicable:

(a) The readability score for a form for which approval is required by this section shall not be less than 45, as determined by the method provided in subdivisions (b) and (c).

(b) The readability score for a form shall be determined as follows:

(i) For a form containing not more than 10,000 words, the entire form shall be analyzed. For a form containing more than 10,000 words, not less than two 200-word samples per page shall be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(ii) Count the number of words and sentences in the form or samples and divide the total number of words by the total number of sentences. Multiply this quotient by a factor of 1.015.

(iii) Count the total number of syllables in the form or samples and divide the total number of syllables by the total number of words. Multiply this quotient by a factor of 84.6. As used in this subparagraph, "syllable" means a unit of spoken language consisting of 1 or more letters of a word as indicated by an accepted dictionary. If the dictionary shows 2 or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(iv) Add the figures obtained in subparagraphs (ii) and (iii) and subtract this sum from 206.835. The figure obtained equals the readability score for the form.

(c) For the purposes of subdivision (b)(ii) and (iii), the following procedures shall be used:

(i) A contraction, hyphenated word, or numbers and letters when separated by spaces shall be counted as 1 word.

(ii) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as 1 sentence.

(d) In determining the readability score, the method provided in subdivisions (b) and (c):

(i) Shall be applied to an insurance policy form or an annuity contract, together with a rider or indorsement form usually associated with such an insurance policy form or annuity contract.

(ii) Shall not be applied to words or phrases that are defined in an insurance policy form, an annuity contract, or riders, indorsements, or group certificates pursuant to an insurance policy form or annuity contract.

(iii) Shall not be applied to language specifically agreed upon through collective bargaining or required by a collective bargaining agreement.

(iv) Shall not be applied to language that is prescribed by state or federal statute or by rules or regulations promulgated pursuant to a state or federal statute.

(e) Each form for which approval is required by this section shall contain both of the following:

(i) Topical captions.

(ii) An identification of exclusions.

(f) Each insurance policy and annuity contract that has more than 3,000 words printed on not more than 3 pages of text or that has more than 3 pages of text regardless of the number of words shall contain a table of contents. This subdivision does not apply to indorsements.

(g) Each rider or indorsement form that changes coverage shall do all of the following:

(i) Contain a properly descriptive title.

(ii) Reproduce either the entire paragraph or the provision as changed.

(iii) Be accompanied by an explanation of the change.

(h) If a computer system approved by the commissioner calculates the readability score of a form as being in compliance with this subsection, the form is considered in compliance with the readability score requirements of this subsection.

(4) After January 1, 1992, any change or addition to a policy or annuity contract form for personal, family, or household purposes, whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form to such policy or annuity contract form, which policy or annuity contract form has not been previously approved under subsection (3), shall be submitted for approval pursuant to subsection (3).

(5) Upon written notice to the insurer, the commissioner may disapprove, withdraw approval or prohibit the issuance, advertising, or delivery of any form to any person in this state if it violates any provisions of this act, or contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. The notice shall specify the objectionable provisions or conditions and state the reasons for the commissioner's

decision. If the form is legally in use by the insurer in this state, the notice shall give the effective date of the commissioner's disapproval, which shall not be less than 30 days subsequent to the mailing or delivery of the notice to the insurer. If the form is not legally in use, then disapproval shall be effective immediately.

(6) If a form is disapproved or approval is withdrawn under the provisions of this act, the insurer is entitled upon demand to a hearing before the commissioner or a deputy commissioner within 30 days after the notice of disapproval or of withdrawal of approval. After the hearing, the commissioner shall make findings of fact and law, and either affirm, modify, or withdraw his or her original order or decision.

(7) Any issuance, use, or delivery by an insurer of any form without the prior approval of the commissioner as required by subsection (1) or after withdrawal of approval as provided by subsection (5) constitutes a separate violation for which the commissioner may order the imposition of a civil penalty of \$25.00 for each offense, but not to exceed the maximum penalty of \$500.00 for any 1 series of offenses relating to any 1 basic policy form, which penalty may be recovered by the attorney general as provided in section 230.

(8) The filing requirements of this section do not apply to any of the following:

(a) Insurance against loss of or damage to:

(i) Imports, exports, or domestic shipments.

(ii) Bridges, tunnels, or other instrumentalities of transportation and communication.

(iii) Aircraft and attached equipment.

(iv) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's compensation or employers' liability arising out of the ownership, maintenance, or use of:

(i) Imports, exports, or domestic shipments.

(ii) Aircraft and attached equipment.

(iii) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Beginning September 1, 1968, the commissioner by order may exempt from the filing requirements of this section and sections 2242, 3606, and 4430 for so long as he or she considers proper any insurance document or form, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, as specified in the order to which this section practicably may not be applied, or the filing and approval of which are considered unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, exempt by order of the commissioner from the filing requirements of this section and sections 2242 and 3606 are considered approved by the commissioner for purposes of section 3430.

(e) Insurance that meets both of the following:

(i) Is sold to an exempt commercial policyholder.

(ii) Contains a prominent disclaimer that states "This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236." or words that are substantially similar.

(9) As used in this section and sections 2401 and 2601, "exempt commercial policyholder" means an insured that purchases the insurance for other than personal, family, or household purposes.

(10) Every order made by the commissioner under the provisions of this section is subject to court review as provided in section 244.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 53, Eff. Sept. 6, 1963;—Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 137, Eff. June 29, 1990;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1993, Act 200, Eff. Dec. 28, 1994;—Am. 2002, Act 664, Eff. Mar. 31, 2003.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to

sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc., 424 Mich 537."

Section 3 of Act 200 of 1993 provides as follows:

"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."

Popular name: Act 218

500.2236a Interest indexed universal life insurance; information to be maintained on file.

Sec. 2236a. All of the following information shall be maintained on file by the insurer for all interest indexed universal life insurance policies:

- (a) A description of how the interest credits are determined, including all of the following:
 - (i) A description of the index.
 - (ii) The relationship between the value of the index and the actual interest rate to be credited.
 - (iii) The frequency and timing that determines the interest rate.
 - (iv) If more than 1 rate of interest applies to different portions of the policy value, the allocation of interest credits.
- (b) The insurer's investment policy, which shall include a description of all of the following:
 - (i) How the insurer addresses the reinvestment risks.
 - (ii) How the insurer plans to address the risk of capital loss on cash outflows.
 - (iii) How the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities.
 - (iv) How the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy.
 - (v) The amount and type of assets currently held for interest indexed policies.
 - (vi) The amount and type of assets expected to be acquired in the future.
- (c) If a policy is linked to an index for a specified period less than the maturity date of the policy, a description of the method to be used to determine interest credits upon the expiration of the period.
- (d) A description of any interest guarantee in addition to or in lieu of the index.
- (e) A description of any maximum premium limitations and the conditions under which they apply.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994.

Popular name: Act 218

500.2237 Group disability insurance policy; prohibited restriction of liability.

Sec. 2237. No policy of insurance issued under the provisions of chapters 34 and 36 of this act, to take effect after June 30, 1962, shall contain any provision restricting the liability of the insurer with respect to expenses, for which payment would be legally required in the absence of insurance, on the ground that such expenses were incurred while the person insured is in a hospital, institution or other facility operated by the state or a political subdivision thereof.

History: Add. 1961, Act 133, Eff. Sept. 8, 1961.

Popular name: Act 218

500.2238 Repealed. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Compiler's note: The repealed section pertained to basic form of policy of insurance of personal property.

Popular name: Act 218

500.2239 Health care service rendered by dentist; benefits or reimbursement; "dentist" defined; policies to which section applicable.

Sec. 2239. (1) If a group or individual hospital, medical, or expense incurred policy delivered, issued for delivery, or renewed in this state provides for benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, “dentist” means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to policies issued or renewed on or after the effective date of this section, and shall apply notwithstanding any policy provision to the contrary.

History: Add. 1982, Act 291, Imd. Eff. Oct. 7, 1982.

Popular name: Act 218

500.2242 Group disability policy; filing and approval of form; grounds for disapproval; notice, hearing, and appeal requirements; withdrawal of approval.

Sec. 2242. (1) Except as otherwise provided in section 2236(8)(d), a group disability policy shall not be issued or delivered in this state unless a copy of the form has been filed with the commissioner and approved by him or her.

(2) The commissioner may within 30 days after the filing of a disability insurance policy form applicable to individual or family expense coverage, disapprove the form for any of the following, subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236:

(a) The benefits provided therein are unreasonable in relation to the premium charged.

(b) It contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy.

(c) It does not comply with other provisions of law.

(3) The commissioner may at any time withdraw his or her approval of an individual or family expense policy form on any of the grounds stated in subsection (2), subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236. An insurer shall not issue the form after the effective date of the withdrawal of approval.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990.

Compiler's note: Section 2 of Act 52 of 1987 provides:

“The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in *Bill v Northwestern National Life Insurance Company*, 143 Mich App 766, with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in *Federal Kemper v Health Insurance Administration Inc.*, 424 Mich 537.”

Popular name: Act 218

500.2243 Group policies; optometric service; coverage.

Sec. 2243. (1) Notwithstanding any provision of a policy or contract of group accident, group health, or group accident and health insurance, executed after July 23, 1965, if the policy or contract provides for reimbursement for any optometric service that is within the lawful scope of practice of a duly licensed optometrist, a subscriber to such group accident, group health, or group accident and group health insurance policy or contract shall be entitled to reimbursement for such service, whether the service is performed by a physician or a duly licensed optometrist. Unless the policy or contract of group accident, group health, or group accident and health insurance otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(2) If a subscriber contract provides for and offers optometric services, the subscriber shall have freedom of choice to select either a physician or an optometrist to render the services. Unless the subscriber contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(3) This section does not require coverage or reimbursement for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

History: Add. 1965, Act 349, Imd. Eff. July 23, 1965;—Am. 1994, Act 438, Eff. Mar. 30, 1995.

Popular name: Act 218

500.2246 Insured or applicant for life insurance policy as victim of domestic violence; refusal to provide coverage prohibited; exceptions; liability; applicability to policies on or after June 1, 1998; “domestic violence” defined.

Sec. 2246. (1) A life insurer that delivers, issues for delivery, or renews in this state a life insurance policy shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a policy solely because an insured or applicant for insurance is or has been a victim of domestic violence.

(2) This section does not prevent any of the following:

(a) An insurer from refusing to issue a life insurance policy insuring an individual who has been the victim of domestic violence if the individual who commits the domestic violence is the applicant for, prospective owner of, or beneficiary under the policy and 1 or more of the following apply:

(i) The applicant, prospective owner, or beneficiary under the policy is known on the basis of police or court records to have committed domestic violence.

(ii) The insurer knows of an arrest or conviction for a domestic violence related offense by the applicant for, prospective owner of, or beneficiary under the policy.

(iii) The insurer has reasonable grounds to believe that the applicant for, prospective owner of, or beneficiary under the policy is committing domestic violence.

(b) An insurer from inquiring about, underwriting, or charging a different premium on the basis of the individual's physical or mental condition, regardless of the cause of the condition.

(c) An insurer from refusing to issue a life insurance policy if the applicant for, prospective owner of, or beneficiary under the policy does not have an insurable interest in the life of the prospective insured individual.

(3) An insurer shall not be held civilly liable for any cause of action that may result from compliance with this section.

(4) This section applies to all life insurance policies issued or renewed on or after June 1, 1998.

(5) As used in this section, “domestic violence” means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

History: Add. 1998, Act 130, Imd. Eff. June 24, 1998.

Popular name: Act 218

500.2248 Automobile insurance; delivery of policy to insured.

Sec. 2248. No policy of insurance against fire, theft, property damage, collision, and/or liability in connection with automobile coverage shall be issued unless the policy, or an exact copy thereof, be delivered to the insured.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2250 Binders or other contracts for temporary insurance; applicability.

Sec. 2250. Binders or other contracts for temporary insurance shall be considered to include all of the terms and conditions of the policy for which application is made. This section does not apply to a life insurance policy.

History: Add. 1990, Act 305, Imd. Eff. Dec. 14, 1990;—Am. 1991, Act 106, Imd. Eff. Oct. 3, 1991.

Popular name: Act 218

500.2254 Action against domestic insurer by member or beneficiary; conditions.

Sec. 2254. Suits at law may be prosecuted and maintained by any member against a domestic insurance corporation for claims which may have accrued if payments are withheld more than 60 days after such claims shall have become due. No article, bylaw, resolution or policy provision adopted by any life, disability, surety, or casualty insurance company doing business in this state prohibiting a member or beneficiary from commencing and maintaining suits at law or in equity against such company shall be valid and no such article, bylaw, provision or resolution shall hereafter be a bar to any suit in any court in this state: Provided, however, That any reasonable remedy for adjudicating claims established by such company or companies shall first be exhausted by the claimant before commencing suit: Provided further, however, That the company shall finally pass upon any claim submitted to it within a period of 6 months from and after final proofs of loss or death shall have been furnished any such company by the claimant.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2260 Life or disability insurance; acts not constituting waiver of defenses.

Sec. 2260. The acknowledgement by any insurer of the receipt of notice given under any life or disability insurance policy or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.2264 Termination of dependent coverage at specified age; exception.

Sec. 2264. Any contract or insurance policy hereinafter delivered in this state providing for hospital care or reimbursement for such care of the policyholders and dependents which provides for termination of dependent coverage at a specified age shall not apply to an unmarried child of the policyholder who is incapable of self-support due to mental retardation or physical disability, and who is dependent upon such policyholder for support and maintenance, if the policyholder submits satisfactory proof of such dependent's incapacity to the insurance carrier not later than 31 days after the attainment of the age limit by such dependent child.

History: Add. 1966, Act 274, Imd. Eff. July 12, 1966;—Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998.

Popular name: Act 218

500.2264a Hospital or medical care coverage or reimbursement for children who are full-time or part-time students and take leave of absence.

Sec. 2264a. (1) Any policy or certificate delivered, issued for delivery, or renewed in this state that provides for hospital or medical care coverage or reimbursement for hospital or medical care for dependent children who are full-time or part-time students shall continue coverage for that dependent student if the dependent student is covered under that policy or certificate and takes a leave of absence from school due to illness or injury. Coverage under this section shall continue for 12 months from the last day of attendance in school or until the dependent reaches the age at which coverage would otherwise terminate, whichever period is shorter.

(2) To qualify for coverage under this section, the dependent student's attending physician shall certify in writing to the dependent's insurer or health maintenance organization that it is medically necessary for the dependent student to take a leave of absence from school.

(3) Coverage under this section shall be provided at the same rate as that charged for dependent student status.

(4) A dependent child must continue to meet all other eligibility requirements for dependent coverage in the policy or certificate if the dependent child takes a leave of absence from school due to illness or injury.

History: Add. 2006, Act 537, Eff. Jan. 1, 2007.

Compiler's note: Former MCL 500.2265a, which pertained to medicare supplemental policies, was repealed by Act 84 of 1992, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.2265-500.2290 Repealed. 1992, Act 84, Imd. Eff. June 2, 1992.

Compiler's note: The repealed sections pertained to medicare supplemental policies and long-term care coverage.

Popular name: Act 218